MONTANA
Department of Public Health & Human Services

ANNUAL SURVEY OF HOME HEALTH AGENCIES 2005

PLEASE RETURN THIS SURVEY NO LATER THAN JANUARY 31, 2006.

Mail or fax a typed or clearly printed copy to: Department of Public Health & Human Services, Certificate of Need Program, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953, fax 444-1742.

Name and Address of Facility:

E-Mail Contact:

Please refer to the instructions on pages 6 and 7 of this survey.

A. REPORTING PERIOD

Required reporting period is January 1, 2005, through December 31, 2005 (except Section G).

1. Was the agency in operation 12 full months at the end of the period? ☐ Yes ☐ No

   If no, please report the number of days the agency was in operation.

B. CLASSIFICATION

1. ☐ NOT FOR PROFIT ☐ FOR PROFIT
2. a. Who holds the license for the facility (corporation/company)?

   b. Who manages the facility (corporation/company)?

3. a. Is your facility operated as part of a chain, whether for profit or not?

   ☐ Yes ☐ No

   b. If YES, please give the name and address of the PARENT organization.

C. OTHER SERVICES

1. Does the agency's owner/organization have programs/departments providing services to clients in addition to, but separate from, the licensed and/or certified home health agency? Data from these programs are not to be included in this survey.

☐ Yes ☐ No

2. If yes, in which of the following categories is that care provided?

Certified Hospice		Outpatient Rehabilitation	
Durable Med Equip		Private Duty Services	
Licensed Home Infusion		Public Health	
Home Oxygen		Medicaid Personal Assistance Services	
Outpatient Chemotherapy		Other:	

D. HOME HEALTH AGENCY - GENERAL INFORMATION

1. Service Availability
   a. Home health services are available: _____hrs a day/_____days a week
   b. Agency office hours are: _____hrs a day/_____days a week

2. Population Served
   Please approximate, by percentage, the agency's client population according to the following age categories:

Under 1 _____%	Age 45-64 _____%	Age 75-84 _____%
Age 1-19 _____%	Age 65-74 _____%	Age 85 and over _____%
Age 20-44 _____%		

COUNTY NAME _____

NOTE: If your agency provides services to more than one county, provide separate "SERVICES AND VISITS" and "PERSONNEL DATA" for each county served. Please reproduce Pages 3 and 4 as necessary.

E. SERVICES AND VISITS

Please read carefully the Instructions, Section E, before completing this section. Remember that information in Sections E and F should reflect CALENDAR YEAR data.

1. Utilization Data: To check your information (a + b - e = f)

a.	Total number of patients on first day of reporting period (January 1, 2005)	
b.	Total number of patient admissions during year	
c.	Total number of patient discharges (include deaths)	
d.	Total number of patients remaining on last day of reporting period	
e.	Total number of patient readmissions	
f.	Total number of unduplicated patients served during calendar year	
g.	Total number of visits made	

2. By discipline:

	No. of People Served	No. of Visits		No. of People Served	No. of Visits
a. Intermittent Skilled Nursing			d. Speech, Hearing Therapy		
b. PT			e. Social Services		
c. OT			f. HHA		

3. By payor source:

PAYOR SOURCE	VISITS	PAYOR SOURCE	VISITS
a. Medicare		e. No Pay Source*	
b. Medicaid		f. Managed Care	
c. Private Health Insurance		g. Other:	
d. Self-Pay		h. TOTAL	

*See Instructions, Section E

COUNTY NAME _____

NOTE: If your agency provides services to more than one county, provide separate "SERVICES AND VISITS" and "PERSONNEL DATA" for each county served. Please reproduce Pages 3 and 4 as necessary.

F. PERSONNEL DATA

1. Please indicate the agency's full-time equivalents (FTEs) as of December 31, 2005. Please read Instructions, Section F, for applicable information.

Discipline	Employees (FTEs)	Contract (FTEs)	Discipline	Employees (FTEs)	Contract (FTEs)
a. Nurses - RN			g. Home Health Aides		
b. Nurses - LPN			h. PTA		
c. Physical Therapists			i. COTA		
d. Occupational Therapists			j. Administrative		
e. Speech Therapists			k. Administrative Support/Clerical		
f. Medical Social Workers			l. TOTAL (All Categories)		

G. FINANCIAL DATA

Please see Instructions, Section G. Financial data should include licensed and/or certified home health agency services ONLY. If actual figures are not available, please estimate (indicate which figures have been estimated). Round to the nearest dollar. **Data in this section should reflect the agency's FISCAL YEAR.**

1. Month of agency's cost report: _____

2. Fiscal year ending date: _____/_____/_____

3. Total annual operating expenses and revenues from agency's most recent annual cost report period.
   a. Total gross revenue $_____
   b. Payroll expenses $_____
   c. Non-payroll expenses $_____
   d. Total expenses (b + c) $_____

4. What is your average cost per visit for all disciplines combined? $_____
   (As shown on the agency's most recent Medicare cost report)

5. Please indicate the charge per visit (dollar amount) for each discipline provided. If there is no charge, enter "None." Also, show cost per visit for each discipline as shown on the agency's most recent Medicare cost report.

TYPE OF SERVICE	CHARGE PER VISIT	COST PER VISIT
a. Intermittent Skilled Nursing		
b. Physical Therapy (PT)		
c. Occupational Therapy (OT)		
d. Speech Therapy (ST)		
e. Medical Social Worker (MSW)		
f. Home Health Aide (HHA)		

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DATE SURVEY COMPLETED __/__/____

ADMINISTRATOR'S NAME (type or print) _____

ADMINISTRATOR'S SIGNATURE _____

If we have questions about any of the responses on this survey, whom should we contact?

NAME _____ TELEPHONE _____

If you have any questions, please contact the Certificate of Need Program, Montana Department of Public Health & Human Services, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. Telephone (406) 444-9519, Fax (406) 444-1742 or E-mail psourbeer@mt.gov

Thank you!

INSTRUCTIONS FOR HOME HEALTH AGENCIES 2005

Address: Please write the name and address of the facility on Page 1 of the survey.

Copies: Mail a typed or clearly printed copy to: Department of Public Health and Human Services, Certificate of Need Program, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. **Keep a copy of the survey for your files**.

Note: Answer every item. Enter "0" to mean none.

A. REPORTING PERIOD

The required reporting period is January 1, 2005, through December 31, 2005, except in Section G, "Financial Data." The reporting period for Section G must coincide with the most current Medicare cost report for the agency.

B. CLASSIFICATION

1. The following definitions apply to this section of the survey:

Not For Profit:	Excess revenue retained by the corporation; exempt from federal income taxation under section 501 of the Internal Revenue Code of 1954.
For Profit (Proprietary):	Excess revenue distributed to owners or shareholders or held as retained earnings, subject to federal taxation.

2. Please indicate the governmental entity (state, city, county or federal), corporation, company, etc., responsible for the ownership and management of the agency.

Data in sections E and F should be reported on a calendar year basis.

E. SERVICES AND VISITS

If the agency serves more than one county, please fill out Sections E, "Services and Visits," and F, "Personnel Data," separately for each county. Pages 3 and 4 are available separately online.

This section should include skilled visits, including skilled nursing, physical therapy, occupational therapy, speech therapy, medical social services, and home health aide, provided through the licensed and/or certified home health agency. These visits can be paid through Medicare, Medicaid, self-pay, private health insurance or other sources. However, they should not include private duty nursing, homemaking, personal assistance, or public health visits. Please report utilization for the full 12-month period.

l.b. "Total number of patient admissions" should include those patients admitted during the survey calendar year. If a patient was admitted, discharged, and later in the year readmitted, that patient would be counted as two admissions.

1.e. "Total number of patient readmissions" should include those patients who were admitted for service, discharged, and later readmitted for service again, regardless of any difference(s) in the diagnosis upon readmission.

l.f. "Total number of unduplicated patients served during calendar year" should include the number of individuals receiving services from the agency for the given calendar year, counted only ONCE, regardless of the number of services, frequency of admission, or payor source.

If a patient was admitted, discharged, and later in the year readmitted, that patient should NOT be counted twice. If a patient is evaluated, but not admitted, that patient should not be counted.

1.g. "Total number of visits made" should not include evaluation visits for patients who are referred but not later admitted.

2. "Number of people served," as broken down by discipline, should reflect a duplicated count of the number of clients served by the agency.

3. The "TOTAL" (E.3.h.) for all of the visits by each payor source should equal the total number of visits shown in E.1.g. "No Pay Source" means visits for which the agency received no payment from any source for billable services.

F. PERSONNEL DATA

The number of full-time equivalents (FTEs) should indicate the sum of annual paid hours for all employees divided by 2,080 hours.

Employee data should exclude private duty nurses, hospice staff, volunteers, and all personnel whose salary is financed by outside research grants.

For combined facilities, report ONLY the personnel for the home health agency.

G. FINANCIAL DATA

The reporting period to be used in this section must coincide with the most current Medicare cost report for the agency. Please indicate the month of the agency's cost report. Where actual figures are not available, please estimate (indicate which figures have been estimated). Please do not use "N/A" in this section. Round all figures to the nearest dollar.

3. a. Total gross revenue: Includes total revenues from direct patient care and all other sources.
   b. Payroll expenses: Report salaries for full-time and part-time personnel as reported in section E, Personnel Data.
   c. Non-payroll expenses: Include all costs for goods and services that have been used or consumed during the reporting period.

Compare financial data with 2004 Annual Survey financial data and explain any differences exceeding 10%.

If you have any questions, please contact the Certificate of Need Program, Montana Department of Public Health & Human Services, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. Telephone (406) 444-9519, Fax (406) 444-1742, or E-mail psourbeer@mt.gov